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No. 85-1763

IN THE

Supreme Court of the United States

October Term, 1985

FLORENCE NIGHTINGALE NURSING HOME,
Petitioner,

against

CESAR PERALES, Individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, Individually and as Administrator/Commissioner of the New York City Human Resources Administration,

Respondents.

Brief of the New York State Health Facilities Association, Inc.; Connecticut Association of Health Care Facilities, Inc.; and American Health Care Association, *Amici Curiae,* In Support of Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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STATEMENT OF INTEREST.

This *amicus curiae* brief is submitted on behalf of the New York State Health Facilities Association, Inc.

(NYSHFA)*, the Connecticut Association of Health Care Facilities, Inc. (CAHCF) and the American Health Care Association (AHCA) in support of the Petition for a Writ of Certiorari herein. All the parties to this litigation have been advised of *amici's* intent to file this brief and have indicated they have no objection to its submission.

NYSHFA is a not-for-profit organization whose membership consists of over 200 health care providers throughout the State of New York. These institutions render "skilled nursing facility" or "intermediate care facility services" as defined in the federal Medicaid Act (42 USC §1396 *et seq.*) to some 30,000 sick and mostly elderly patients. Approximately 70% of these patients are Medicaid recipients.

CAHCF is the Connecticut counterpart to NYSHFA. It represents approximately 170 facilities serving a total of 18,375 skilled nursing and intermediate care facility patients. Approximately 65-70% of those patients are Medicaid recipients. These facilities, like those in New York, are within the jurisdiction of the Second Circuit Court of Appeals, and are affected by the decision below.

AHCA, headquartered in Washington, D.C., is the national association of health care facilities with whom both NYSHFA and CAHCF are affiliated. It represents a broad spectrum of over 9,000 private, religious and charitable skilled nursing and intermediate care facilities throughout the United States, serving approximately 850,000 patients, a significant percentage of whom (the exact amount is unknown) are Medicaid recipients.

*As a not-for-profit corporation NYSHFA has no stock. It is, however, the sole stockholder of a subsidiary for-profit corporation, the New York State Health Facilities Service Corporation. It has no parents or other affiliates.

Amici, NYSHFA, CAHCF, and AHCA, all have a significant interest in the outcome of this litigation because of the broad participation by their membership in the Medicaid program. The issue in this case is whether or not any state may force facilities participating in the program within its borders to collect a portion of the rates federal law says the states must pay them from the impoverished, sick and elderly patients they serve.

Below, the State of New York argued that if a facility is unable to collect that portion (known as "NAMI"*) from the patients, the facility is not entitled to receive it from the State, despite the fact that the State has itself determined that these amounts are necessary for the facility to ensure the provision of quality care.

The State has acknowledged that for fiscal year 1983-1984 alone, the NAMI portion owed to facilities amounts to nearly $300 million.** Since a survey of NYSHFA facilities showed that approximately two percent of NAMIs were uncollectible in 1985, approximately six million dollars owed to long-term care facilities for the care of Medicaid patients will be left unpaid within New York State alone if the Second Circuit decision is allowed to stand.***

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*NAMI is an acronym for "net available monthly income". That refers to the amount, which varies from patient to patient, which the State determines an eligible recipient or his family is responsible for when he/she is determined to be eligible for Medicaid. 42 CRF §§435.725, 435.832.

**See Petition for Certiorari at 9, fn 4.

***This figure is based on the response by 86 member facilities to a May 1986 survey conducted by NYSHFA. No similar survey was conducted by the other *amici.* Although exact figures are therefore unavailable, the amount nationwide must obviously be considerably greater.

Amici strongly concur with the Petitioner that Congress never intended that facilities participating in the Medicaid program were to be ultimately responsible for collecting reimbursement from the many poor patients they serve. Medicaid reimbursement to facilities is and was at all times relevant hereto the sole responsibility of the states. If allowed to stand, the Second Circuit's decision will require NYSHFA's and CAHCF's members to assume that financial risk. Moreover, if followed by courts outside the Second Circuit, it will affect the membership of AHCA as well.

Assumption of that risk is not only onerous but is particularly unfair. The Medicaid Act gives facilities no control over the eligibility determinations states make. The significance of this has assumed even greater proportions for NYSHFA because facilities in many New York locations are now being required to admit a specified percentage of Medicaid patients in order to meet the "public need" requirement for construction or "establishment" approval by the Public Health Council of the State Health Department. New York Public Health Law § 2801-a.3 (McKinney 1985). The Health Department considers the number of Medicaid patients admitted as an indicator of public need for such approvals, and it is considering support for legislation or regulation to require all facilities to accept a certain percentage of Medicaid patients.* It is grossly unfair that facilities in New York be required by the State to accept Medicaid patients, if they are to receive no assurance of payment from the State as a result of the decision below.

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*Office of Health Systems Management, New York State Department of Health, Draft Report "Assuring Access of Medicaid Patients To Residential Health Care Facilities in New York State" April, 1986, and Minutes of Public Health Council meeting of April 18, 1986 pgs. 7-14.

SUMMARY OF ARGUMENT.

This case affects every hospital, skilled nursing and intermediate care facility in the country which participates in the Medicaid program. Illegally shifting the cost of a legislatively enacted social program onto providers dramatically reduces the amount of reimbursement these facilities will receive despite the fact that the states themselves have determined those amounts to be necessary to the facilities in order to provide adequate quality care.

The decision could, as well, precipitate substantial withdrawals by such institutions from the Medicaid program nationwide. This was precisely what Congress sought to avoid when it first enacted the present cost-based reimbursement methodology for nursing homes and intermediate care facilities in 1972. 42 U.S.C. §1396a(a)(13)(E)*; P.L. 92-603 §249.

The decision below was wrong. The Second Circuit confused the Medicaid law and regulations governing the establishment and payment of rates under 42 U.S.C. §1396a (a)(13)(A)—the responsibility for which rests solely with the states—with the Medicaid laws and regulations governing the financial eligibility of recipients under 42 U.S.C. §1396a(a)(17). The eligibility and reimbursement laws and regulations were, until this decision, separate and

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*Subparagraph (E) was amended in 1980, P.L. 96-499, §962(a), changing the standard from "cost-related" reimbursement to a standard requiring that reimbursement be sufficient to cover the costs of economically and efficiently operated facilities in order to insure that they will be able to provide quality care. By Public Law 97-35, §725, subparagraph (E) was relettered to subparagraph (A) as it appears in the present law. All parties agree that these changes have no effect upon the issue presented herein.

distinct. The court's merger of the two and failure to read them *in pari materia* has resulted in a clearly erroneous decision. It has shifted onto providers the responsibility for collecting significant amounts of reimbursement from the recipients themselves even though the facilities have no "legal say" under the Medicaid laws in determining Medicaid eligibility—which is the sole responsibility of the states. 42 U.S.C. §1396a(a)(5).

The Second Circuit decision not only reverses two different decisions by the District Court in this matter but is also inconsistent with the only other Circuit Court of Appeals decision on this issue. *Seneca Nursing Home v. Secretary of Social and Rehabilitation Services,* 604 F.2d 1309 (10th Cir. 1979). To clarify confusion in the Circuits on this issue and to correct an erroneous Second Circuit decision of nationwide impact, the Petition for Writ of Certiorari should be granted.

ARGUMENT.

I. This Case Could Have Profound National Implications For The Medicaid Program.

This case will be closely watched throughout the country. Its significance is perhaps best reflected by the fact that the U.S. Government sought and obtained permission from the Second Circuit Court of Appeals to file an *amicus* brief in this matter below.

If the decision is allowed to stand, other states will most surely be tempted to emulate New York's example and shift all financial responsibility for payment of NAMI's onto the facilities themselves. It could also induce many providers to withdraw their participation in the pro-

gram—a result Congess desperately sought to avoid when it first enacted the cost-based reimbursement methodology. 41 Fed. Reg., 27,303 (1976). *DeGregorio v. O'Bannon,* 500 F. Supp. 541, 543-545 (D.C., E.D. Pa. 1980). What, then, will happen to all the patients in such facilities? They have no right to remain in facilities which withdraw from the program. *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773 (1980). *Roberson v. Wood,* 500 F. Supp. 854 (D.C., S.D. Ill. 1980).

The result could be the *de facto* destruction of an important social program designed to provide access to health care for millions of elderly Americans who otherwise could not afford it. This comes at the very time the State of New York has expressed its great concern at the difficulty Medicaid patients already encounter in obtaining access to nursing homes.* At the very least, the Second Circuit's decision will unfairly burden many facilities by shifting permanently onto them a cost that logically and legally should be borne by Government rather than the private sector. The total fiscal impact of the decision cannot be assessed, but based upon the State's own estimates within New York alone,** the nationwide repercussions are enormous.

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*Office of Health Systems Management, New York State Department of Health, Draft Report "Assuring Access of Medicaid Patients To Residential Health Care Facilities in New York State" April, 1986, p. 1 and Minutes of Public Health Council meeting of April 18, 1986, pgs. 7-14.

**See Petition for Certiorari at 9 fn 4.

II. The Decision Of The Circuit Court Was Erroneous.

A. The Court Misapprehended The Distinction Between "Rates" And "Costs".

The heart of the Second Circuit's opinion can be found in the following language:

> The District Court determined that the statute "clearly calls for a cost-based reimbursement program." 570 F. Supp. at 288. But the District Court did not reckon with the fact that "reasonable cost basis" applies only to the cost of "services provided under the plan." In authorizing reimbursement of providers for Medicaid care costs Congress clearly intended *not* to reimburse for costs not covered by Medicaid. NAMI represents the amount that a patient is required to contribute toward his or her care. This contribution reduces the amount that the patient is eligible to have paid on his or her behalf under the Medicaid program. (Emphasis supplied.)

Petition for Cert. at A-4.

This excerpt from the Second Circuit's opinion reveals the fundamental error in its analysis as well as a lack of understanding of the Medicaid rate-setting process. The *rate* facilities are entitled to be paid is determined by the State totally without regard to the NAMI. It is a function of *costs* already determined by the State's methodology*

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*In New York State, that methodology is set forth in regulations. 10 NYCRR 86-2.1 *et seq.* Those regulations, approved by the Secretary of Health and Human Services, say absolutely nothing about the NAMI.

which the U.S. Secretary of Health and Human Services has already found to be "satisfactory." 42 USC §1396a(a)(13)(A). The Medicaid reimbursement rate in New York State is determined completely independently of the NAMI. One has nothing to do with the other.

The rate is determined by the costs incurred in providing the service, not by who pays for it. It costs no more or less to provide Medicaid services to a patient who does or does not pay a NAMI. The amount of the NAMI does not reduce the rate the facility is entitled to be paid for services rendered under the program. The NAMI never entered into the rate calculation process to begin with and was never a "cost" as erroneously assumed by the Circuit Court. Since it was not a cost that entered into the rate, it is clearly wrong to deduct it from the rate for services rendered.

Once the Second Circuit made this erroneous "linkage" between the costs involved in calculating the rate and the NAMI, the wrong conclusion it reached was inevitable.

B. The Court Improperly Confused Those Portions of The Law Dealing with Rates With Those Dealing With Eligibility.

In confusing NAMI's with rate setting, the Second Circuit lost sight of the central purpose behind the Medicaid program and the role facilities play in it. The whole point of 42 USC §1396a(a)(13)(A) was to make sure that the facilities were paid for the costs they incurred in efficiently and economically providing quality care. In order to encourage their participation in the program, Congress sought to relieve facilities of the worry about receiving payment from individuals who obviously could not have paid for their care.

The courts have long recognized that the cost of nursing care under the Medicaid program is to be shared by the patient, the states and the federal government. See e.g. *James v. Harris,* 499 F. Supp. 594, 597 (D.C., M.D. Ala. 1980). Nowhere is there any indication that this responsibility was to be shifted to the facility. *DeGregorio v. O'Bannon,* 500 F. Supp. 541; 41 Fed. Reg. 27,300 *et seq.* (1976).

The District Court clearly understood the central purpose of the Medicaid program and the providers' role noting the necessity for their receiving payment *in full. Florence Nightingale Nursing Home v. Blum,* 570 F. Supp. 285, 289, fn 2. The Tenth Circuit also understood this in *Seneca Nursing Home v. Secretary of Social and Rehabilitation Services, supra* at 1311.

Those parts of the Medicaid law and regulations dealing with the NAMI and cited by the Second Circuit have absolutely nothing to do with the provider. They relate solely to "eligibility" determinations, an issue between the State and the recipient, not the provider. If a recipient wishes to be covered under the program, he/she has to pay whatever the lawful NAMI portion for that particular patient may be. If he does not, the states cannot require the facility to absorb the loss for services rendered under the program.

Merging eligibility and reimbursement regulations ignores and perverts the intent of Congress. The states are supposed to pay the facility its rate based on costs. Where the states get the money to pay the facility is their problem, not the facility's. In interpreting and reading the various provisions of the Medicaid Act *in pari materia,* the specific requirements for cost-related reimbursement in §1396a(a)(13)(A) mandating payment take precedence

over other general language in the statute. *Children's Memorial Hospital v. Illinois Department of Public Aid,* 562 F. Supp. 165, 171 (D.C., M.D. Ill. 1983).

In *Children's Memorial Hospital, supra,* the court found certain reimbursement limitations in a state Medicaid plan conflicted with the national public interest articulated in subparagraph 13(A) of §1396a(a). There the court also emphasized that courts should not always defer to an administrative agency's self-serving regulations* and statutory interpretations when there are, as here, "compelling indications" that the agency interpretation is wrong. 562 F. Supp. at 170. *Espinoza v. Farah Manufacturing Company,* 414 U.S. 86, 94-95 (1973); *Red Lion Broadcasting Co. v. FCC,* 395 U.S. 367, 381 (1969).

C. The Second Circuit's Decision Unfairly Places The Burden Of Collection On The Providers.

The federal Medicaid Act clearly places the sole responsibility for determining patient eligibility on the state agency responsible for administering a program within a state's border. 42 U.S.C. §1396a(a)(5). New York implements this by placing that responsibility exclusively with the Department of Social Services. New York State Social Services Law, §364, subd. 1(e) (McKinney 1983).

*The Second Circuit's opinion appeared to rely heavily on 42 CFR §§435.725 and 435.832 (1984). Petition for Certiorari at A-5. Those regulations, however, were issued by the Secretary of Health and Human Services to avoid any governmental responsibility for the NAMIs. Since Medicaid is a joint federal-state program, the less the state expends, the less the federal government has to pay as part of its share. 42 U.S.C. §1396b. However, the Secretary's "bootstrapping attempt" by regulation to escape responsibility for payment cannot supersede the overriding obligation placed on the states and the federal government by Congress to pay rates to facilities based on their costs.

Facilities have absolutely no "say" whatsoever as to whom the states approve for financial eligiblity. Nor do they have any jurisdiction, control or administration over the amount of NAMI established for such patient. The states, on the other hand, have enormous resources at their disposal to determine eligibility. Yet, under this decision it is the facility that is forced to assume the financial burden of chasing down that patient's resources. This is particularly onerous in a large state, like New York, with a significant percentage of patients eligible for Medicaid. Frequently these patients are disabled and/or incompetent and it is their relatives who control their resources.* In many cases it is virtually impossible to identify those relatives or locate the whereabouts of their assets.

If the states are to determine how much a patient must contribute toward his/her care, the states are the ones which should collect it, not the providers who give the care but have no control over the financial eligibility determination in the first place. It was never Congress's intent to place this burden upon providers.

III. The Second Circuit's Decision Conflicts With A Decision By The Tenth Circuit.

In *Seneca Nursing Home v. Secretary of Social and Rehabilitation Services,* 604 F.2d 1309 (10th Cir. 1979), a clearly different result was reached from the decision by the Second Circuit in the case at bar. While the Second Circuit took great pains to distinguish *Seneca, supra,* on

*It is neither moral nor realistic to discharge the patients in such cases. They are usually too sick to be discharged and too incompetent to know where their money is. They are the innocent but helpless victims of their families' refusal to turn the NAMI money over to the facilities.

the grounds that the case turned on Kansas law, statutory language in all states is and must be effectively the same insofar as placing the responsibility for determining Medicaid eligibility squarely on the State ageny that administers the program within its borders. 42 U.S.C. §1396a(a)(5). The Tenth Circuit clearly indicated that the Kansas statute, as well as its own holding, was premised on meeting federal statutory guidelines set forth in 42 U.S.C. §1396 *et seq. Seneca, supra* at 1315.

The distinction between Kansas and New York is, therefore, illusory and irrelevant. The key point is that throughout the country, eligibility determinations are to be made in all cases by a state agency. Providers were given assurances by the federal government that they would be paid for the services rendered. After doing so, they should not have to bear the brunt of the patients' refusal to pay amounts which the state determined are necessary to provide quality care.

Confusion will certainly abound throughout the country by virtue of the clearly opposite results reached by the Second Circuit in the case at bar and the decision by the Tenth Circuit in *Seneca, supra.* The court should resolve these inconsistent results and establish a truly uniform national policy as intended by Congress.

CONCLUSION.

The Petition for a Writ of Certiorari should be granted. In addition, because of the significance of this case, the court should receive the views of as many responsible interested parties as possible. Accordingly, NYSHFA, CAHCF, and AHCA should be granted *amici curiae*

status in this case and be permitted to file any further brief as warranted by the grant of certiorari.

Dated: June 24, 1986

Respectfully submitted,

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